

Registration District No. **266**Primary Registration District No. **4164**

## 1. PLACE OF DEATH:

- (a) County **Dunk**  
(b) City or town **Salem**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution (Specify whether

In this community  
years, months or days)8. (a) PRINT  
FULL NAME**Harold Frank & Anderson**

8. (b) If veteran,  
name war

3. (c) Social Security  
No.

4. Sex **m.**

5. Color or  
race **w**

6. (a) Single, widowed, married,  
divorced **0**

6. (b) Name of husband or wife

6. (c) Age of husband or wife if  
alive **14** years  
(Day) (Year)

7. Birth date of deceased

**Jan 14 1941**  
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

**7** hr. min.

9. Birthplace

**Salem Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name **Frank W. Anderson**

13. Birthplace **Springfield Mo**  
(City, town, or county) (State or foreign country)

14. Maiden name **Eva Emma Jensen**

15. Birthplace **Sterling Iowa**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Frank W. Anderson**

- (b) Address **Salem Mo**

17. (a) **Buried** (b) Date thereof **1/15/41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation **Green Road**

18. (a) Signature of funeral director **240**

- (b) Address

19. (a) **January 15 1941** (b) **F. E. Sullivan**  
(Date received by registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State **mo** (b) County **Dunk**

- (c) City or town **Salem**  
(If outside city or town limits, write "RURAL")

- (d) Street No. (If rural, give location) **0**

- (e) If foreign born, how long in U. S. A.? years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **14**  
year **1941** hour **4:00** minute **0** M.

21. I hereby certify that I attended the deceased from  
**Jan 14 1941**, to **1/14/41**, 19\_\_\_\_;  
that I last saw him alive on **1/14/41**, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death

**Pneumonia  
with cerebral hemorrhage.**

Duration

**8 hours**

Due to

Due to

Other conditions  
(Include pregnancy within 3 months of death)Major findings:  
Of operations

Of autopsy

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **M. Grossman** (M. D. or other) **0**

Address **Salem Mo** Date signed **1/15/41**

RECEIVED

District Health Officer No. 5,

District File Number. 241266

Date Filed \_\_\_\_\_

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, above space should be left blank.